

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-63-016012

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

DO NOT WRITE
ON THIS STUD

AMENDED

Registration District No. 13

Primary Registration District No. 1002

Registrar's No.

STATE FILE NUMBER

VS 300
Rev. 4/59

1

23 X 28

3

4 0

5 1

6

7 1

8 1

9 X

10

11 123

12 57-3

13

USE BLACK INK
OR
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

BY AFFIDAVIT OF
HUGH H. OWENS

| | | | |
|---|--|--|-------------------------------------|
| 1. PLACE OF DEATH a. COUNTY JACKSON | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY JACKSON | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) KANSAS CITY | | c. CITY OR TOWN KANSAS CITY | |
| Length of stay in 1b 10 YEARS | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |
| c. FULL NAME OF (If NOT in hospital, give location) K.C. GENERAL HOSPITAL | | d. STREET ADDRESS (If outside, give location) 7900 EAST 48TH TERRACE | |
| Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) ROBERT THOMAS EGGERS | | 4. DATE OF DEATH Month APRIL Day 27 Year 1963 | |
| 5. SEX MALE | 6. COLOR OR RACE WHITE | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH 4-9-1931 |
| 9. AGE (last birthday) 32 | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MANAGER | |
| 11. BIRTHPLACE (City and state or country) ROCKFORD, ILLINOIS | | 12. CITIZEN OF WHAT COUNTRY U.S.A. | |
| 13a. FATHER'S NAME JOHN EGGERS | | 13b. MOTHER'S MAIDEN NAME KATHERINE KERNAN | |
| 14. NAME OF HUSBAND OR WIFE MRS. SHARON EGGERS | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) YES | |
| 16. SOCIAL SECURITY NO. 7900 EAST 48TH TERRACE | | 17. INFORMANT MRS. SHARON EGGERS | |
| 18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) perforated skull contusions DUE TO (b) Chest DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) | | PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown | |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 20a. ACCIDENT <input checked="" type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/> | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) no car collision | |
| 20c. TIME OF INJURY Hour 4:27 a.m. 63 Month, Day, Year | 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | |
| 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Street | | 20f. CITY, TOWN, OR LOCATION KANSAS CITY | |
| 20g. COUNTY JACKSON | | 20h. STATE MO | |
| 21. I attended the deceased from _____, to _____ and last saw her alive on _____. Death occurred at 9:55 A. m on the date stated above, and to the best of my knowledge, from the causes stated. | | | |
| 22a. SIGNATURE Hugh H. Owens | | 22b. ADDRESS 152 Union Station | |
| 22c. DATE SIGNED 4-27-63 | | 22d. NAME OF CEMETERY OR CREMATORY FLORAL HILLS CEMETERY | |
| 22e. LOCATION (City, town, or county) KANSAS CITY | | 22f. STATE MISSOURI | |
| 23a. FUNERAL DIRECTOR D.W. NEWCOMER'S SONS | | 23b. ADDRESS 1331 BRUSH CREEK | |
| 23c. DATE RECD. BY LOCAL REG. 4-29-63 | | 23d. REGISTRAR'S SIGNATURE Ruth Long | |

(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed

Thomas W. Hanson

Licensed Embalmer No. 4889

P. O. Address

St. Louis, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.